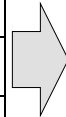


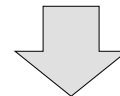
PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT REGISTRATION

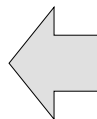
DATE			
LAST NAME	FIRST	M.I.	
PREFERS TO BE CALLED BY			
ADDRESS			
CITY	STATE	ZIP	
CELL PHONE NO.	HOME PHONE NO.		
EMAIL			
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			



DENTAL INSURANCE	
PRIMARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
INSURED'S BIRTHDATE	RELATIONSHIP TO PATIENT
INSURED'S ID NUMBER	
INSURED'S SOCIAL SECURITY NO.	



PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT	
NAME	
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.
ADDRESS	
CITY	STATE ZIP
PRIMARY PHONE NO.	
YOUR ACCOUNT INFORMATION	
OCCUPATION	
EMPLOYER'S NAME	
EMPLOYER'S ADDRESS	CITY
WORK PHONE NO.	FAX NO.
YOUR SPOUSE'S ACCOUNT INFORMATION	
SPOUSE'S NAME	
OCCUPATION	
EMPLOYER'S NAME	
EMPLOYER'S ADDRESS	CITY
WORK PHONE NO.	FAX NO.



GETTING TO KNOW YOU	
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?	
NAME:	
RELATIONSHIP:	
YOU WERE REFERRED TO US BY	
NAME:	
YOUR FORMER ADDRESS	
ADDRESS	
CITY	STATE ZIP
PERSON TO CONTACT FOR EMERGENCY	
NAME	PHONE NO.
ADDRESS	
CITY	STATE ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU	
NAME	PHONE NO.
ADDRESS	
CITY	STATE ZIP

The above information is accurate to the best of my knowledge:

Patient/Guardian Signature: _____ Date: _____

Print Name: _____